

2016 SELECT PLAN (80/20 PPO) ENROLLMENT FORM



Read instructions on reverse side to complete form • Please print in dark black or blue ink or type

NOTE: The Pensioner is the individual currently receiving monthly pension benefits from the Cincinnati Retirement System.

PENSIONER INFO	1 Social Security No.		Last Name		First Name		Initial		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth Mo. Day Yr.			Enrollment Date						
	Home Address										City		State		Zip Code					
	Home Phone Number			Work Phone Number			Cell Phone Number			Email Address										
MEDICARE	2 UPON ELIGIBILITY - MEDICARE BECOMES YOUR PRIMARY INSURANCE COVERAGE																			
	<input type="checkbox"/> Pensioner Medicare A No. _____ Effective Date ____/____/____ Spouse Medicare A No. _____ Effective Date ____/____/____ <input type="checkbox"/> Pensioner Medicare B No. _____ Effective Date ____/____/____ Spouse Medicare B No. _____ Effective Date ____/____/____																			
DEPENDENT INFORMATION	3 List below pensioner, spouse and all unmarried dependent children for whom health care coverage is being requested. The pensioner MUST be covered by each plan (medical, dental, vision) for which they are requesting coverage for a spouse or dependent.																			
											CIRCLE YES OR NO TO INDICATE DESIRED COVERAGE									
	Name First M Initial Last		Relationship		Date of Birth Mo. Day Yr.			Sex (M or F)		Social Security No.			MEDICAL		DENTAL		VISION			
			SELF										YES NO		YES NO		YES NO			
													YES NO		YES NO		YES NO			
													YES NO		YES NO		YES NO			
													YES NO		YES NO		YES NO			
MONTHLY PREMIUM	4																			
	MEDICAL					PENSIONER + CHILD(REN)					DENTAL					VISION				
	Pensioner ONLY					Non-Medicare \$49.66					Pensioner \$35.66					Pensioner \$3.12				
	Medicare Eligible \$18.34					Medicare Eligible \$33.78					Pensioner + Spouse \$71.35					Pensioner + Spouse \$5.93				
	PENSIONER + SPOUSE					PENSIONER + SPOUSE + CHILD(REN)					PENSIONER + SPOUSE + CHILD(REN)					PENSIONER + SPOUSE + CHILD(REN)				
	Both Non-Medicare \$98.01					Both Non-Medicare \$117.86					Pensioner + Child(ren) \$69.56					Pensioner + Child(ren) \$6.23				
Non-Medicare + Medicare Eligible \$66.68					Non-Medicare + Medicare Eligible \$86.53					Pensioner + Spouse + Child(ren) \$105.23					Pensioner + Spouse + Child(ren) \$9.17					
Both Medicare Eligible \$35.36					Both Medicare Eligible \$55.21															

I certify all information is true and correct to the best of my knowledge. I understand that by applying for the type of coverage checked, I authorize my pension system to deduct from my pension benefit payment, the required premiums for the coverage hereon applied for. I further authorize any provider of medical, dental or vision services, insurance company or any other organization to release to Anthem Blue Cross & Blue Shield any information regarding my coverage.

Pensioner Signature _____ Date _____ Retiree Name (if different than Pensioner) _____